MARICOPA COUNTY

SPENDING ACCOUNT ENROLLMENT FORM

BEFORE YOU COMPETE THIS FORM, PLEASE READ THE OTHER SIDE

PLAN YEAR

_____

WRITE THE PLAN YEAR HERE

BENEFITS OFFICE USE ONLY

Effective Date: _____

Hire Date: _____

Validation: _____

PLEASE PRINT OR TYPE USING BLACK INK

REASON FOR FORM

☐ **New Hire** ☐ **Open Enrollment** ☐ **Cancellation** ☐ **Address Change**

☐ **Name change (Former Name):** _____

☐ **Family Status Change:** _____

Are you a MIHS Employee? ☐ **Yes** ☐ **No**

EMPLOYEE INFORMATION

*** DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER (SSN) IS MANDATORY UNDER THE FEDERAL TAXATION LAWS AND WILL BE USED ON A EMPLOYEE'S W-2'S**

SOCIAL SECURITY #	EMPLOYEE ID	LAST NAME	FIRST NAME	MI	DEPT

MAILING ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE
		AZ		

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Health Care Flexible Spending Account (FSA) pays for certain health care expenses not covered by insurance. Before you decide how much to set aside in your account, use the estimator on the back of this form. The Plan Year contribution is limited to $5,200. The full Plan Year has 26 pay periods and runs from January 1 through December 31. If you enroll after the beginning of the Plan Year, your Plan Year begins on your FSA benefit effective date. If you terminate employment prior to the end of the Plan Year, your Plan Year ends on the last day of the pay period in which you made a contribution. You can elect to continue this benefit through COBRA.

☐ **I elect to make a contribution to a Flexible Health Care Spending Account for January 1 through December 31 of the Plan Year above.**

$ _____ **X** _____ **PAY PERIODS = $** _____

PER PAY PERIOD DEDUCTION (178) PLAN YEAR ELECTION (178)

CHILD DAY CARE or ELDER DAY CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Care Flexible Spending Account (FSA) pays for dependent care (childcare or elder day care) expenses. Plan Year contributions are limited to $5,000. However, if you are married and file a separate tax return, the maximum annual contribution is limited to $2,500. If you are married and file a joint tax return, the maximum annual contribution is limited to the lessor of your earned incomes. The full Plan Year has 26 pay periods and runs from January 1 through December 31. If you enroll after the beginning of the Plan Year, your Plan Year begins on your FSA benefit effective date. If you terminate employment prior to the end of the Plan Year, your Plan Year ends on the last day of the pay period in which you made a contribution. This benefit may not be continued through COBRA. Please note this benefit may not be used to cover your dependents' health care expenses.

☐ **I elect to establish a Dependent Care Flexible Spending Account for January 1 through December 31 of the Plan Year above.**

$ _____ **X** _____ **PAY PERIODS = $** _____

PER PAY PERIOD DEDUCTION (177) PLAN YEAR ELECTION (177)

CHECK ONE: ☐ **Single** ☐ **Married Filing Jointly** ☐ **Married Filing Separately**

STATEMENT OF UNDERSTANDING

You must have a "Qualified Status Change" as defined by the Internal Revenue Code Section 125 in order to change flexible spending accounts after you make your election. Please review the CHANGE IN STATUS DEFINITIONS section of the MARIFLEX guide for further information on when you can make changes during the Plan Year.

By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents as described in the Maricopa County Notice of Privacy Practices, with my health care providers, which could include, CIGNA, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), United Concordia, Employers Dental Service (EDS), UnumProvident, AVESIS, Application Software Inc. (the flexible spending account administrator) and WHI in its role as Pharmacy Benefits Manager. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of PHI in connection with my benefits or as otherwise authorized or required by law.

EMPLOYEE SIGNATURE _____ **DATE** _____

FLEXIBLE SPENDING ACCOUNT ESTIMATOR

In general, you may use your Health Care Spending Account to pay for health care expenses NOT covered by insurance that would qualify as IRS tax deductions (i.e., deductibles, copayments, and other out-of-pocket expenses for the prevention, diagnosis, treatment and care of a physical or mental illness, injury or disease and transportation for necessary health care).

Money contributed to your Flexible Spending Account(s) (health care and/or dependent care) is tax-free and therefore not subject to federal, state, or social security taxes. Since unused account balances at the end of the year are forfeited, it is important to accurately estimate your total out-of-pocket expenses for the upcoming year. This estimator will help you figure out how much you may wish to deposit.

ESTIMATING YOUR HEALTH CARE SPENDING ACCOUNT

ESTIMATED COSTS

1. Total estimated medical plan deductible from the effective date of your plan participation to 12/31. **$** _____
2. Total estimated dental plan deductible from the effective date of your plan participation to 12/31. **$** _____
3. Total estimated copayments for medical and dental from the effective date of your plan participation to 12/31. **$** _____
4. Total estimated uncovered vision care expenses (e.g., eye exams, glasses, and contact lenses) from the effective date of your plan participation to 12/31. **$** _____
5. Total estimated health care expenses not covered by insurance (e.g., orthodontia, hearing aids) from the effective date of your plan participation to 12/31. **$** _____
6. **TOTAL YOU MAY WISH TO DEPOSIT**. (Total of 1 through 5) **$** _____ **(TO 12/31)**

NOTE: TO ESTIMATE THE AMOUNT THAT WILL BE DEDUCTED FROM EACH PAYCHECK

DIVIDE THE **TOTAL YOU MAY WISH TO DEPOSIT $** _____ BY _____ PAY PERIODS **= $** _____

PAY PERIOD DEDUCTION

ESTIMATING YOUR DEPENDENT CARE SPENDING ACCOUNT

ESTIMATE YOUR DAY CARE EXPENSES

NUMBER OF WEEKS BEGINNING FROM YOUR EFFECTIVE DATE OF PLAN PARTICIPATION

TO 12/31 _____ **X** ESTIMATED COST PER WEEK $ _____ **= ESTIMATE** $ _____

(TO 12/31)

NOTE: TO ESTIMATE THE AMOUNT THAT WILL BE DEDUCTED FROM EACH PAYCHECK

DIVIDE THE **ESTIMATE $** _____ BY _____ PAY PERIODS **= $** _____

PAY PERIOD DEDUCTION

HIGHLIGHTS OF RULES FOR THE FLEXIBLE SPENDING PROGRAM

- ✓ During the open enrollment period, I must complete a Flexible Spending Account Enrollment form in order to participate in either the health care or dependent care Flexible Spending Account for the following calendar year.
- ✓ If I enroll after the beginning of a new Plan Year, my contribution will only be used for expenses I incur from the effective date of my participation until the end of the current Plan Year.
- ✓ I may not change or stop my deposits to either Flexible Spending Account during the Plan Year unless my family status changes (birth or adoption of a child, divorce, marriage, death, or change in a spouse's employment).
- ✓ I will forfeit any unused account balance at the end of the Plan Year.
- ✓ Expenses paid through my Flexible Spending Accounts are not eligible for individual tax credits or personal deductions on my income tax return.
- ✓ The payroll deductions I have authorized will be made on a before-tax basis in equal installments over the 12-month period beginning with my first paycheck in January, or if participation begins during the year, the first paycheck after the effective date of my participation and will be in equal installments during the remainder of the Plan Year.
- ✓ If I miss some payments and if I do not change my election (in the event of a qualified family status change) in the flexible spending program; upon my return the pay period deduction amount will be recalculated based on my annual pledge minus my year-to-date contributions divided by the number of pay periods remaining in the calendar year.